TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Emergenchealth LLC

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-23-0016-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
September 1, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 14, 2021	01270 QZ	$1753.70	$1753.70
	Total	$1753.70	$1753.70

Requestor's Position

"Please find attached a completed DWC Form 60 for the above listed patient and date of service. The carrier has denied payment of our claim stating, 'the time limit for filing has expired. We provided services to this patient and the face sheet we received form the facility instructed us to bill Blue Cross Blue Shield for payment. …Once that payment was posted to the patient's account a co-insurance balance remained, and we sent the patient a statement for that balance. The patient set the statement she received to the State Office of Risk Management. They forwarded the statement to our office, along with a letter stating our service must be billed on a CMS 1500. We billed our claim to the State Office of Risk Management as soon as we learned of our billing error. We received a denial from the carrier for timely filing."

Amount in Dispute: $30,248.47

Respondent's Position

"The Office performed an in-depth review of the dispute packet submitted by Emergenchealth and respectfully request this request this request for medical fee dispute resolution be dismissed

due to not being eligible for review pursuant to 28 TAC Rule §133.307 (f)(A) as the requestor has failed to submit a request for reconsideration in accordance with 28 TAC 133.250 ."

Response Submitted by: State Office of Risk Management

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.20 sets out requirements of medical bill submission.

3. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.

4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for the disputed service.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired

Issues

1. Did the requestor support timely submission of medical claim?
2. What rule is applicable to disputed service reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution for anesthesia services administered in September 2021. The insurance carrier denied the medical bill as not submitted timely.

   To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute:

   TLC §408.027(a) states, "A health care provider shall submit a claim for payment to the

insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

TLC §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

> (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
>
> > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
> >
> > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
> >
> > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

DWC Rule 28 TAC §133.20(b) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."

The DWC reviewed all the documentation and finds:

- The date of service in dispute is September 14, 2021.
- The requestor submitted an EOB from BlueCross BlueShield that noted carrier processed the claim on October 14, 2021. This date is within the 95-day timeline to submit a bill.

- On January 6, 2022, SORM acknowledged receipt of statement for disputed services.,
- On January 18, 2022, the requestor was notified that the claim needed to be submitted on CMS-1500.
- The reviewed documentation contained a copy of a 1500 claim form dated January 31, 2022, for the disputed service addressed to the State Office of Risk Management.
- An explanation of benefits from SORM dated February 11, 2022. Denied the disputed service.

TLC §408.0272(b)(1) provides for the exception to timely filing based upon three scenarios noted above.

The requestor supported that the bill was sent to the respondent within 95 days after being notified of the correct workers' compensation carrier.

The respondent's denial of payment based upon timely filing is not supported.

2. The fee guidelines for disputed services are found at 28 TAC §134.203. which states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   DWC Rule 28 TAC 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT Code 01270 -QZ is described as "Anesthesia for procedures involving arteries of upper leg including bypass graft, not otherwise specified."

   The requestor appended modifier "QZ- CRNA service: without medical direction by a physician" to code 01270. The CMS Medicare Claims Processing Manual, Chapter 12, Section 50 (B) at www.cms.gov, states, "*The physician and the CRNA (or anesthesiologist's assistant) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the AA modifier and the CRNA reports the QZ modifier.*"

   DWC Rule 28 TAC §134.203(c)(1) states in pertinent part, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies

with minimal modification…For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is date of service yearly conversion factor." The DWC conversion factor for CY 2021 is $61.17.

Per Medicare Claims Processing Manual, Chapter 12, Physicians/Nonphysician Practitioners, Payment for Anesthesiology Services, Section (50)(G), effective January 1, 2021, states, "Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place."

Review of the submitted medical record indicates the requestor billed for 310 minutes; therefore, 310/15 = 20.7

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

- Total time 20.7.
- CMS Base units for Code 01270, 8 units.
- The 2021 DWC conversion factor for this service is 61.17.
- 20.7 + 8 x 61.17 = $1,755.58

3. The total MAR is $1,755.58. The requestor is seeking $1,753.70. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that State Office of Risk Management must remit to Emergenchealth LLC $1,753.70 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

May 19, 2023

Signature Medical Fee Dispute Resolution Officer Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.